Sandy Stone, LPC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservice.com **539-777-1129**

CONSENT FOR SERVICES

This document contains important information about my professional services and business policies. Please read this thoroughly and write down any questions you have so we can discuss them at our next appointment. By signing this document, it will represent an agreement between you and me.

PSYCHOLOGICAL SERVICES

The general purpose of psychological services is to help alleviate the suffering of an individual through psychological treatment by examining and changing unhelpful thoughts, feelings, and behaviors that are contributing to dissatisfaction. The manner in which treatment is conducted varies based on the personalities of the psychologist and client, the particular problems being addressed, and the treatment modalities used. My main modality is Cognitive Behavioral Therapy. If Christianity, or other aspect of spirituality, is a part of your perspective on life, I will also incorporate aspects of spirituality if desired. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful I will give you homework to do in between our appointments so that you will be able to integrate our discussions and insights into your daily life and begin to make changes.

Psychotherapy can have risks and benefits. Psychotherapy often involves discussing unpleasant aspects of your life and you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and worry. Psychotherapy can also lead to changes in the way you think or behave; these changes may be difficult for people in your life to grow accustomed to and thus some relationships may experience temporary strain. On the other hand, psychotherapy has been shown to have powerful benefits. Psychotherapy often leads to better relationships, solutions to specific problems of daily living or health, significant reductions in feelings of distress, and an improved sense of well-being. There are no guarantees of what risks and benefits you may experience, although again, there is considerable evidence that most people benefit from psychotherapy when they are actively involved in the sessions.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation phase (typically 1-3 sessions) I will offer you some impressions of what our work will include. If, at the end of this time, I do not feel that I am the best clinician to treat you, I will provide you with a referral to another clinician. I will ask for your feedback so that you and I can draft a treatment plan together that will address all the needs for which you are seeking psychotherapy. Therapy involves a significant commitment of time, money, and energy, so your input and comfort level with the process is of utmost importance. If you have concerns about my methods or our therapeutic relationship please bring them to my attention as soon as possible so that we can discuss them. If at any time you would like to work with another therapist I will be happy to provide an appropriate referral.

EVALUATION & PSYCHOTHERAPY SESSIONS

The evaluation phase typically lasts 1-3 sessions. During this time I will be gathering information about your current, and past, problem. We will also determine if I am the appropriate person to provide your treatment. We will decide if weekly, biweekly, or monthly sessions are appropriate to help you reach your goals. Sometimes weekly appointments are extended in duration, or we may need to meet twice a week,

depending on your individual needs. However, it's most typical that one 45-50 minute appointment each week is sufficient. I strongly encourage you to make several appointments in advance so you can keep your ideal day/time slot. This also allows us to use the full appointment time for therapy instead of discussing scheduling. You are responsible for arriving for your appointments on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next client's appointment.

PROFESSIONAL FEES

My hourly (45-50 minutes) fee for psychotherapy (face-to-face or telemedicine) service is $140. Phone consultation, emailing or writing letters, preparing reports or treatment summaries, communication with family, friends, other health care providers, legal representatives, and attendance at meetings with other persons you have authorized will be billed to you incrementally at the same hourly rate of $140.

CANCELLATIONS AND MISSED APPOINTMENTS

Once an appointment is scheduled, you will be expected to pay for that appointment unless you provide 24 hours advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. To cancel an appointment you may leave a voicemail at 539-777-1129 which has a time and date stamp for the message. I will charge the credit, debit, or health savings account card on file for the full fee of $140.00, or if you pay by cash or check you must pay $140.00 for the missed appointment at your next visit before additional appointments will be scheduled. You will be charged $140 for a no-show or late cancellation even if you are using your health insurance to pay for services. If I am unable to attend a scheduled appointment and fail to provide you with 24 hour notice, then you will not be charged for your next session. The same emergency exception applies for me for circumstances out of my control.

BILLING AND PAYMENTS

I accept cash, check, credit, debit, and health saving cards from Visa, MC, American Express, and Discover. I use a state of the art practice management software system that securely stores your billing information for all sessions and you will be billed at the end of your appointment day. If you opt to pay for services with cash or check, payment will be taken at the beginning of each appointment. If a check bounces the associated bank charges paid by me, as well as the time associated with managing the bounced check, will be added to your balance. If you have two bounced checks or two appointments for which you have not paid for services rendered, services will be discontinued until your account is up to date.

If your account remains outstanding I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary the associated costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided (e.g. psychotherapy), and the amount due. No private information regarding the specifics of any treatment will be disclosed.

INSURANCE REIMBURSEMENT

I offer services on a fee-for-service basis. For clients who wish to use their out-of-network benefits, I provide

a billing invoice which can be submitted to your insurance company if you wish to seek reimbursement. This billing invoice contains confidential information, including your name, date of service, service provided, and diagnosis. Please call your insurance company to determine your out-of-network benefits.

CONTACTING ME

My administrative staff are available Monday-Thursday between 9am – 5pm and can be reached on the main office line (539-777-1129) or through email (intake@legacycounselingservice.com). I will be alerted to messages that need my personal attention. Do not leave messages related to your treatment or mental health concerns on voicemail or email as non-clinical staff will have access to these messages. Please keep messages focused on scheduling or billing issues only. Also, be aware that communication through email becomes a part of your clinical/legal documentation. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, crisis center (918-744-4800, 1-800-273-TALK (8255), call 911, or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. Please note that I am not available via text messaging.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records for 7 years. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging. Due to the professional nature of these records, they can be misinterpreted and/or upsetting to untrained readers. In the event I do not release records to you, I will be happy to provide you with a treatment summary or will send them to another mental health professional of your choosing. If I provide you with your full records I recommend that we review them together so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information to an outside party about our work together with your written permission. However, there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony through a court order or subpoena if he/she determines that the situation demands such testimony. In this case I may have to release records to the court.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child/minor, elderly person, or disabled person is being abused or neglected, I am required to file a report with the appropriate state agency. If I believe that you, the client, is threatening serious bodily harm to self or another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If you, the client, threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or

others who can help provide protection. These situations occur infrequently. If a situation like this occurs, I will make every effort to fully discuss it with you before taking any action.

In order to provide optimal care, I may consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you, but if you require formal legal advice I recommend speaking with an attorney because the laws governing confidentiality are quite complex.

PUBLIC ENCOUNTERS

There may be instances during which a clinician and a client encounter each other outside of the therapy setting (grocery store, bank, gym, movies, etc). Please note that in the event that we encounter each other in public I will not initiate acknowledgement of any kind (e.g., smile, wave, say "hello", etc.). This is an effort to protect your privacy and confidentiality so that you are not put in a position where you may feel pressure to explain to a person you are with how you know me or the nature of our relationship. If YOU decide to acknowledge me then I will acknowledge you in return in a simple manner but will not initiate or encourage conversation. Please keep in mind that it is not appropriate to discuss, with me, treatment, homework, or new struggles, if we do encounter each other in public.

SOCIAL MEDIA POLICY

FRIENDING

I do not accept or solicit friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Twitter, Pinterest, Instagram, Google +, etc). This policy is in place to protect your confidentiality and privacy, and to protect the professional limits of our therapeutic relationship.

COMMENTING ON SOCIAL MEDIA

I maintain social media sites (Facebook, Linked In, Pinterest, etc.) as a means of providing the public with general information about mental health and healthy coping strategies. You are welcome to view or “like” my posts on social media, but I ask that if you are a current or past client that you do not comment on posts to protect your confidentiality and anonymity. Should you choose to make a comment on a post please be aware that I cannot guarantee your anonymity or confidentiality. Additionally, the American Psychological Association’s Ethics Code prohibits providers from soliciting testimonials from current or former clients. Should you accidentally post commentary on my social media sites that appears to be a testimonial I will remove your comments to protect you from accidental disclosure of our professional relationship and to avoid an ethical conflict. I will also remove your comments if I feel that too much personal information has been disclosed. Again, you are strongly encouraged not to post comments on my social media platforms.

INTERACTING THROUGH SOCIAL MEDIA

Please do not contact me via text, wall posts, @replies, or private message through any social media platform. These sites are not secure, and again I cannot guarantee your confidentiality. Additionally, I may not check these platforms regularly. I will not respond to any efforts to communicate with me through these venues. Direct phone calls to me are the best way to communicate with me.

USE OF SEARCH ENGINES

Only under rare and extreme situations would I consider it permissible to search for a client on a social media platform. These situations would be if I believed that you may be in danger to yourself or others and I am unable to contact you through the typical means of an appointment or phone. Such searches or contacts with those acquainted with you will be documented in your clinical chart.

Summary Statements from this Informed Consent:

- Psychotherapy services are $140 per 50-minute therapy hour.
- I provide a billing invoice which can be submitted to your insurance company if you wish to seek reimbursement.
- Fees for services rendered will be automatically charged to the card you have on file, unless paying with cash or check. Payment is taken at the beginning of each session.
- I bill, incrementally, at the hourly rate of $140.00 for any additional professional services I provide beyond the office visit and will be charged to the credit card on file.
- Please notify me of cancellations at least 24 hours in advance by leaving a voicemail (539-777-1129) or sending an email to intake@legacycounselingservice.com. If you cancel less than 24 hours before your appointment, I will bill you the full fee for the appointment unless you have had a true emergency. Please note that text messaging is NOT available as an option for contacting me.
- If you cancel twice in a row with less than 24-hour notice, or if you miss a total of two scheduled appointments without notifying me, I reserve the right to suspend services.
- Digital communication with me via email or cell phone may not be secure and is monitored by my administrative staff. I am legally and ethically obligated to protect the confidentiality of all communication with you in the actual office and through record keeping, but I cannot protect all digital communication that occurs outside my office (via phone or email).
- I have read and understand the Social Media policy and agree not to communicate with Mrs. Stone through social media platforms. I understand that if I choose to communicate through social media platforms that my confidentiality, privacy, and anonymity cannot be guaranteed by Mrs. Stone.
- I cannot guarantee around-the-clock availability and am not available before 9am or after 4:30pm Monday through Friday, or on Saturdays or Sundays. If you should experience a behavioral or emotional crisis and you cannot reach me by phone, you should contact 911 or go to the nearest emergency room. You can also call the Crisis Hotline at 1-800-273-8255.

Sandy Stone, LPC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservice.com **539-777-1129**

CLIENT ACKNOWLEDGEMENT OF PRIVATE PAY

_____ **Private pay**
Client Signature

CLIENT CONSENT TO PSYCHOTHERAPY
I have read this statement carefully and have been afforded the opportunity to ask questions so that I understand the contents. I understand that I can return to this document at any time to discuss these policies with Mrs. Stone, and am encouraged to do so during the initial appointment. I agree to pay the fee of $140.00 per 45 - 50-minute session. I understand my rights and responsibilities as a client, and my psychologist's responsibilities to me.

I agree to undertake psychotherapy with Mrs. Sandy Stone. I understand that I can terminate therapy services at any time and that I can refuse any requests or suggestions made by Mrs. Stone. I am over the age of eighteen and have legal authority to sign this agreement.

_____ _____
Client Signature: **Date:**

_____
Client Printed Name:

Sandy Stone, LPC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservice.com **539-777-1129**

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information I create and obtain in providing services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

YOUR HEALTH INFORMATION RIGHTS:
The health record and billing records I maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to my office. I am not required to grant the request, but I will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at my office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to my office using the form provided to you upon request.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to my office using the form provided to you upon request.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to my office using the form provided to you upon request. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to my office using the form provided to you upon request.
- Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to my office.
- You have the right to review this Notice before signing the consent authorizing use and disclosure of

your protected health information for treatment, payment, and health care operations purposes.

MY RESPONSIBILITIES
The provider is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to my duties and privacy practices as to the information I collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if I cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information to you.

You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services. I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment. I cannot, and will not, retaliate against you for filing a complaint with the Secretary.

NOTIFICATION:
Unless you object, I may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other persons responsible for your care, about your location, about your general condition, or your death.
COMMUNICATION WITH FAMILY:
Using my best judgment, I may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
DISASTER RELIEF:
I may use and disclose your protected health information to assist in disaster relief efforts.
FUNERAL DIRECTORS/CORONERS:
I may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
MARKETING:
I may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits or services that may be of interest to you.
PUBLIC HEALTH:
As required by law, I may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

ABUSE AND NEGLECT:
I may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

LAW ENFORCEMENT:
I may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

HEALTH OVERSIGHT:
Federal law allows me to release your protected health information to appropriate health oversight agencies or for health oversight activities.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS:
I may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order. To avert a serious threat or health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

FOR SPECIALIZED GOVERNMENTAL FUNCTIONS:
I may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

OTHER USES:
Other uses and disclosures in addition to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

By signing below you indicate that you have read the above Privacy Notice:

_____ _____
Signature of Client or Personal Representative **Date**

_____
Printed Name of Client or Personal Representative

Sandy Stone, LPC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservice.com **539-777-1129**

ELECTRONIC PAYMENT/STORAGE AUTHORIZATION

I (printed name), _____, authorize Legacy Counseling Service, LLC, to securely encrypt and store credit card information for the purpose of payment for services rendered or for late cancellation/no-show appointments as noted in the Informed Consent.

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service.

_____ _____

Cardholder Signature **Date**

Sandy Stone, LPC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservice.com **539-777-1129**

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

Over the ***LAST 2 WEEKS***, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Troubling falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Troubling concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
If you check off ***ANY*** problems, ***HOW DIFFICULT*** have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult

OFFICE USE ONLY: Total Score: 1-4 = Minimal Depression; 5-9 = Mild Depression; 10-14 = Moderate Depression; 15-19 = Moderately Severe Depression; 20-27 = Severe Depression

Sandy Stone, LPC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservice.com **539-777-1129**

GAD-7

Over the ***LAST 2 WEEKS***, how often have you been bothered by the following problems?				
	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it is hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3

Office Use Only: Total Score: 1-4 Minimal Anxiety; 5-9 Mild Anxiety; 10-14 Moderate Anxiety; 15-21 Severe Anxiety

Please rate the **current (i.e., last 2 weeks)** severity of your insomnia problem(s).

		None	Mild	Moderate	Severe	Very
a.	Difficulty falling asleep:	0	1	2	3	4
b.	Difficulty staying asleep:	0	1	2	3	4
c.	Problem waking up too early:	0	1	2	3	4

2. How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
0	1	2	3	4

3. To what extent do you consider your sleep problem to interfere with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.).

Not at all interfering	A little	Somewhat	Much	Very much interfering
0	1	2	3	4

4. How noticeable to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all noticeable	A little	Somewhat	Much	Very much noticeable
0	1	2	3	4

5. How worried/distressed are you about your current sleep problem?

Not at all worried	A little	Somewhat	Much	Very much worried
0	1	2	3	4

OFFICE USE ONLY: Total Score: 0-7 No clinically significant insomnia; 8-14 Subthreshold insomnia; 15–21 = Moderately Severe Clinical insomnia; 22–28 = Severe Clinical insomnia

Sandy Stone, LPC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservice.com **539-777-1129**

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #: _____

I hereby authorize _____Sandy Stone, LPC

to release the following information to:

_____

_____

_Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for_____ **X** Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between _____and_____

☐Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Insurance **X** Continued Treatment ☐ Legal ☐ At my or my representative's request ☐ Other:____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Description of Legal Representative's Authority | Expiration date (if longer than one year from date of signature or no event is indicated